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Hypertension follow-up Initial assessment

Adult Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

52-year-old woman attending review of high blood pressure. Care stage: At the first supervised assessment.

Medical history: Hypertension was diagnosed earlier. The patient sometimes misses prescribed tablets because the routine is difficult to maintain. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Usually feels well but sometimes misses tablets.

Objective findings and required checks: Repeated appropriately measured blood pressure is above the agreed target.

Physical examination and investigations: Review repeated readings, cardiovascular risk, renal function, electrolytes and indicated urine assessment.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Hypertension follow-up: Persistent raised arterial pressure increases long-term vascular and organ risk.

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Medical / surgical management

Confirm measurement technique, assess adherence and support prescribed medicines and realistic lifestyle changes.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed antihypertensive	Lower blood pressure in the individualized regimen	Monitor blood pressure, postural symptoms and drug-specific tests
medication reconciliation	Identify missed or interacting products	Discuss changes with the prescriber.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Usually feels well but sometimes misses tablets. Repeated appropriately measured blood pressure is above the agreed target. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize difficulty sustaining the agreed treatment plan; reduced circulation to vulnerable tissues; vulnerability to a fall or accidental injury; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Confirm measurement technique, assess adherence and support prescribed medicines and realistic lifestyle changes. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about missed treatment, side effects, cost and beliefs without blame. Assess: Review the medication list, refill access and ability to follow instructions.	Difficulty sustaining the agreed treatment plan. Possible factors: treatment burden, access barriers or uncertainty. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Identifies one practical barrier and agrees on a feasible solution. Longer-term: Before the clinically approved transition or agreed follow-up: Has an affordable treatment and follow-up plan verified with the team.	1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different responses. 2. Reconcile medicines and involve pharmacy or community services when needed. Rationale: A simpler, accurate plan can reduce avoidable errors. 3. Agree reminders, support and follow-up using shared decision-making. Rationale: Plans are more sustainable when they fit the person's circumstances. 4. Confirm measurement technique, assess adherence and support prescribed medicines and realistic lifestyle changes. Rationale: Persistent raised arterial pressure increases long-term vascular and organ risk. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about dizziness, chest discomfort, fatigue	Reduced circulation to vulnerable tissues. Possible	Short-term: After the first indicated intervention, at the	1. Trend perfusion findings and escalate new chest pain, shock or altered consciousness immediately.	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
and cold extremities. Assess: Assess consciousness, pulse, blood pressure, capillary refill and urine trend.	factors: altered blood flow or cardiac function. Validate against the patient's assessment.	documented review time: Circulation and consciousness remain within the clinician-agreed targets. Longer-term: Before the clinically approved transition or agreed follow-up: Describes symptoms that require immediate review and the agreed follow-up plan.	Rationale: Poor circulation can rapidly threaten organ function. 2. Balance activity and rest and maintain the ordered monitoring schedule. Rationale: Reducing demand supports recovery while trends guide treatment. 3. Administer prescribed therapy and monitor effects and adverse reactions. Rationale: Response monitoring supports safe correction of the underlying problem.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about falls, dizziness, vision and usual walking aids. Assess: Assess gait, medicines, cognition and environmental risks.	Vulnerability to a fall or accidental injury. Possible factors: unsteady mobility, dizziness or environmental hazards. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Transfers and essential activity occur without a fall during the care period. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates safe use of assistance and identifies home hazards.	1. Individualize fall precautions and keep necessary items and the call bell accessible. Rationale: Accessible support reduces unsafe unassisted movement. 2. Supervise transfers according to assessed need and check footwear and aids. Rationale: Correct assistance and equipment improve stability. 3. Review reversible contributors with the team, including postural symptoms and medicines. Rationale: Addressing causes improves safety beyond environmental measures.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale:	Record the baseline and reassessed finding, the time and whether this goal is met,

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
identify specific gaps.	prior teaching. Validate against the patient's assessment.	action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach home measurement if advised, adherence, salt reduction, activity and follow-up. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach home measurement if advised, adherence, salt reduction, activity and follow-up.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Very high pressure with chest pain, neurological symptoms, severe breathlessness or visual change needs urgent assessment.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Persistent raised arterial pressure increases long-term vascular and organ risk.

- Priority concerns: Difficulty sustaining the agreed treatment plan; Reduced circulation to vulnerable tissues; Vulnerability to a fall or accidental injury; Learning needs about the condition and care plan.

- Very high pressure with chest pain, neurological symptoms, severe breathlessness or visual change needs urgent assessment.

- Teach home measurement if advised, adherence, salt reduction, activity and follow-up.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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